STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150004	A. BUILDING _____ B. WING _____	12/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN ST MARGARET HEALTH - HAMMOND	5454 HOHMAN AVE HAMMOND, IN 46320

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for investigation of a State hospital complaint. Complaint Number: IN00091595 Substantiated: No deficiencies related to allegations are cited. Date: 12/20/11 Facility Number: 005004 Surveyor: Jacqueline Brown, R.N. Public Health Nurse Surveyor Franciscan St. Margaret Health - Hammond is in compliance with 410 IAC 15-1.5-6, Nursing service, Indiana Hospital Licensure Rules. QA: claughlin 02/03/12	S 000		